SHINING THE GLOBAL SPOTLIGHT ON THE LINKS BETWEEN OBESITY AND MENTAL HEALTH

By Ann Y. Du, Ana S. Ayala and Daniel Hougendobler

In September 2011, the United Nations General Assembly convened a high-level meeting that culminated in a pivotal political declaration, acknowledging that non-communicable diseases are a major challenge for social and economic development, particularly for developing countries. Recognizing the social and economic impacts of NCDs on development, the declaration highlights how NCDs could create serious impediments for a country in meeting the Millennium Development Goals.

This article examines the legal and policy initiatives at the international and regional levels, looking to see how they address the intersection of mental health and obesity. The article begins by briefly examining existing research on the medical link between mental health and obesity. Having set this foundation, it then surveys the various existing international and regional legal and policy documents that can serve as a launching point for focusing efforts to address the mental health within the context of obesity. Finally, the discussion turns to how governments and the international community can take advantage of current global initiatives relevant to health, including the post-2015 development agenda and universal health coverage movement, while also providing recommendations on how national governments can help address the problem at the domestic level.

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In September 2011, the United Nations General Assembly convened a high-level meeting that culminated in a pivotal political declaration, acknowledging that non-communicable diseases (NCDs) are a major challenge for social and economic development, particularly for developing countries. Recognizing the social and economic impacts of NCDs on development, the declaration highlights how NCDs could create serious impediments for a country in meeting the Millennium Development Goals (MDGs)—sadly not one MDG focuses on NCDs. With the MDGs expiring in 2015, health campaigners are pushing for greater recognition of NCDs in the post-2015 development agenda.

While NCDs have become the foremost priority on the global health agenda, too little attention has been paid to the medical link between obesity and mental health, both in research and in policy. Although more medical research is needed to understand the contours of the intersection between mental health and obesity, the studies that have already been conducted strongly suggest a link. However, existing laws, policies, and programs have not yet caught up to the research. Effective health policy must originate from all levels of governance: domestic, regional, and international. In this article, we examine the legal and policy initiatives at the international and regional levels, looking to see how they address the intersection of mental health and obesity. We conclude by calling for greater action at all levels of government and provide recommendations on how governments can improve their efforts in tackling the mental health implications of obesity.

Part II begins by briefly examining existing research on the medical link between mental health and obesity. Having set this foundation, Part III then surveys the various existing international and regional legal and policy documents that can serve as a launching point for focusing efforts to address the mental health within the context of obesity. In Part IV, the discussion turns to how governments and the international community can take advantage of current global initiatives relevant to health, including the post-2015 development agenda and universal health coverage movement, while also providing recommendations on how national governments can help address the problem at the domestic level.

II. THE MEDICAL LINK BETWEEN MENTAL HEALTH AND OBESITY

There is a strongly suggestive, yet incomplete, scientific literature linking obesity with mental illness—in particular depression. Although more study is needed, it seems likely that (at least in some populations) the causal relationship flows in two directions: mental illness can lead to increased risk of obesity and obesity can also lead to mental illness. In others, it may lead in one direction but not the other, or there may be no correlation at all. This section provides a brief review of some of the scientific literature.

Several studies have found a relationship in the general adult population, both men and women. For example, one review of 15 separate studies found that obesity was linked to depression and depression to obesity. In Norway, higher body mass was linked to depression in both men and
In Alameda County, California, a study of men and women over the age of 50 showed a significant correlation of obesity to depression, but did not show a correlation in the other direction. Notably, extreme obesity among men and women has been linked to depression in both Europeans and African Americans. Moreover, another robust survey of over 4,300 British adults found that mental illness was correlated with obesity (but not vice versa). It also found that where mental illness was chronic or repeated, the risk of obesity was significantly greater.

However, there is countervailing evidence. One systematic review, for instance, found “a weak level of evidence” of obesity leading to depression. Despite this, the bulk of studies appear to show some level of correlation, particularly among certain subpopulations.

Women may be particularly affected by the link between mental health and obesity, and particularly to obesity leading to depression. An especially powerful prospective study showed a bi-directional relationship in middle-aged and older women. In this study, 66,000 female nurses from the United Kingdom were given regular surveys between 1996 and 2006. After controlling for a wide range of potentially confounding variables, a statistically significant, bi-directional correlation remained. An international survey, which covered five continents, showed a modest, but statistically significant, relationship between obesity and emotional disorders among women, but did not find a significant relationship for men. Another linked severe obesity to depression in women of all ages, but not in men.

Several studies have also shown a link among children and adolescents, populations that may be uniquely vulnerable. One found an association between childhood obesity and mental illness. Another showed statistically significant increase in depression and anxiety among obese adolescent girls.

There is also some evidence that socio-economic status and education may be correlated with increased obese individuals developing depression. However, there is disagreement in the literature about whether those of high or low socioeconomic status are more susceptible.

The causal mechanisms are not well understood, but researchers have proposed several possibilities for... [let’s state it explicitly]. First, some biological disorders may cause both mental illness and obesity. Also, depression is often associated with sedentary behavior, which makes obesity more likely. Some medications used to treat mental disorders are associated with weight gain. Some biological disorders can affect both mental health and are linked to obesity, e.g. certain hormonal imbalances. Obese individuals may face actual or perceived stigma or may suffer lower self-esteem due to their body image. Similarly, depression may lead to reduced social support, which can lead to or exacerbate obesity. There is also some evidence that repeated dieting, and dieting failure, may be linked to depression.

There is an urgent need for additional research into the links between obesity and mental illness, particularly among different subpopulations, in regions other than the United States and Europe, and for mental illnesses other than depression. However, the literature thus far is highly suggestive of a causal link between obesity and depression, particularly in the United States and Europe.

III. INTERNATIONAL INSTRUMENTS
Global legal and policy efforts have lagged behind the research in the field of obesity. This section surveys the legal and policy instruments developed at the global level that would aid in drawing the link between obesity and mental health.

The World Health Assembly (WHA), is the plenary decision-making body of WHO but its resolutions are general in nature and do not offer specific policies for states to adopt. Nevertheless, it has issued a handful of resolutions addressing mental health and obesity. Most significantly, it has authored a resolution that acknowledges the direct connection between mental health and NCDs, encouraging states to “[e]xplicitly include mental health within general and priority health policies, plans and research agenda, including noncommunicable diseases.”[25] This resolution reflects member states’ recognition of the need to understand and combat these issues collectively, rather than continuing to perceive them as separate challenges to health. However, WHA resolutions lack binding legal force and function more as calls to action rather than as guides for the implementation of policies. For example, WHA Resolution 65.4 urges the Director-General to submit a Mental Health Action Plan, which was then adopted by WHA Resolution 66.8 in 2013, but the substantive policy recommendations themselves are located in the action plan and not the resolution.[26]

WHO has adopted one chief document addressing the prevention of NCDs and three addressing mental health. However, it has yet to produce a resolution that directly addresses the connection between the two, although the provisions in all relevant reports refer to the causal relationship between them, albeit sometimes in general terms. The Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020 (a follow-up to the 2008-2013 action plan with the same name) was adopted in 2013 by WHA Resolution 66.10.[27] While the original 2008-2013 action plan mentioned mental health only in a footnote, the 2013-2020 action plan makes several references to mental health, including in the policy recommendation sections for both the Secretariat and member states.[28] The updated version recognizes that “mental disorders are an important cause of morbidity and contribute to the global burden of noncommunicable diseases” and that “they can be a precursor or consequence of a noncommunicable disease, or the result of interactive effects.”[29] Significantly, it calls on states to place special emphasis within NCD prevention and control programs on at-risk populations, including people with “psychological disabilities.”[30] In addition, it encourages states to implement a comprehensive mental health plan which could include policies such as expanding the types and quality of services offered, establishing a policy that requires human resources officers and personnel to be specially trained to handle mental health-related issues, and improving the efficiency of delivery of mental health services.[31]

The main documents addressing mental health authored by WHO are the Mental Health Policy and Service Guidance Package, the 2008 Mental Health Gap Action Programme, and the Global Mental Health Action Plan 2013-2020. In addition, to these policy-based programs, WHO published the Assessment Instrument for Mental Health Systems in 2005.[32] The assessment instrument was designed to be a standardized tool to be used by all regional offices while gathering and analyzing relevant information. This tool is essential for allowing states to measure and compare data using a standardized yardstick.

WHO guidance has not been limited to governments. Between 2003 and 2007, WHO published the Mental Health Policy and Service Guidance Package, a series of documents designed for use by all stakeholders, including advocates, research institutions, and civil society.[33] The package aims to “develop policies and comprehensive strategies for improving the mental health of
“provide effective services to those in need [and] assist the reintegration of persons with mental disorders into all aspects of community life, thus improving their overall quality of life.”[34] The first module provides context on the current global situation in regards to mental health, and outlines some of the social and economic factors that exacerbate mental health issues.[35] It acknowledges that the international community needs to produce responses in the economic, legal, and governance sectors and outlines the steps necessary to plan, finance, and implement a program to promote positive mental health in a country.[36] The second module adds more detail to the method for developing effective plans and programs while the third module is concerned with the creation of monitoring and evaluation mechanisms.[37] Rather than offering specific policy recommendations, the package seeks to lay out the necessary steps to create and actualize a high-quality national mental health program. Though viewed together the documents offer a comprehensive approach to tackling the issue of mental health, they lack the necessary references to obesity. In order to decrease rates of mental health problems, policies to combat obesity must also be addressed in the documents.

The 2008 Mental Health Gap Action Programme was designed to increase financial and human capital dedicated to tackling the issue of mental health.[38] Central to the publication is a table that lists the most successful evidence-based interventions for the eight priority mental health disorders.[39] The table also includes suggested policies that could be tailored and adopted by states depending on their individual social and economic situation.[40] In addition, the 2008 program called on the international community to develop a framework to monitor and evaluate the policies implemented by states to increase accountability.[41] More significantly, it also pushed for the formation of a mechanism to locate the states most in need of improvement and the creation of tailored intervention packages for each such state based on the resources available and the most pressing conditions faced by the country.[42] This targeted approach towards progress, though initially more resource-intensive, is necessary for change to occur. In the long-run, this approach is also likely to be more efficient because it recognizes that not all countries have to implement all recommendations related to combating mental health problems to be successful, and instead pushes only for the adoption of policies that are most relevant to the circumstances of the particular state.

Finally, the Global Mental Health Action Plan 2013-2020 is WHO’s most recent resolution addressing mental health.[43] It divides its recommendations by actor type: member states, Secretariat, and allied international and national organizations, although there is a great deal of overlap between the policies found in each category. It calls on member states to increase the number of national programs developed and monitor their implementation; collaborate with relevant stakeholders, including the families of those with mental illnesses; and ensure there is sufficient budget and resources devoted to this overcoming this challenge.[44] The plan also promotes several normative policies, such as introducing laws that address the disparity, discrimination, and stigmatization affects that often accompany mental health issues.[45] It calls on the Secretariat to compile a set of best practices from different states and circulate them within the international community to increase the flow of innovation, which is critical for allowing states and regions to access a greater breadth of information.[46]

INTERNATIONAL HUMAN RIGHTS TREATIES

Of the various U.N. human rights-based treaties, only two refer to issues related to either mental
health or obesity, and none address the connection between them. The first is the Convention on the Rights of the Child (CRC). Article 24(c) obliges states to include within their primary healthcare framework a “provision of adequate nutritious foods and clean drinking-water” for children.[47] In addition, the convention calls on states to protect the mental health of children in relation to mass media and when a child is placed under the care of authorities for care and treatment.[48] The Committee on the Rights of the Child published General Comment 7 in 2005 to expand upon the provisions in the CRC. Paragraph 27 addresses the healthy start provisions in Article 27, which require states to provide access to good nutrition to reduce the potential of obesity and unhealthy lifestyles.[49] However, the convention is only binding on the states that have signed and ratified the document.

The second treaty is the International Covenant on Economic, Social and Cultural Rights (ICESCR), which acknowledges “the right of everyone to an adequate standard of living,” including in relation to the “principles of nutrition.”[50] Although the treaty does not directly address obesity, it does recognize the important role that nutrition and diet play in a healthy lifestyle. In addition, the ICESCR grants the right to each individual of “the enjoyment of the highest attainable standard of physical and mental health.”[51] This recognition of the need to support positive mental health as well as physical health is a significant step forward, although it is referred to only briefly in the treaty.

While it is commendable that global bodies such as the WHO and the UN have produced a number of instruments addressing mental health and obesity, the existing documents alone are insufficient to battle these escalating crises. Moreover, no institution has yet to create a framework or action plan with guidelines on how to tackle the causal link between the two issues, which is necessary in order to successfully achieve progress in either issue alone.

IV. REGIONAL INSTRUMENTS

At the regional level, WHO regional offices have and can continue to play an important role in recognizing that link between obesity and mental health. However, it is worth noting, that the policies and action plans have varied greatly in terms of content, approach, goals, and overall effectiveness. This section provides an overview of the legal and policy instruments that the six regional offices of WHO have developed. It also offers an insight into the extent to which NCDs threaten each region and whether the region is appropriately addressing the issue of obesity and mental health.

A. Africa

The African continent faces several challenges that the other regions do not. A fundamental problem is the lack of sufficient research conducted and evidence to support the development of effective policies in this region. The Regional Office for Africa (AFRO) recognizes this dearth of sufficient medical evidence, particularly in the field of mental health.[52] For example, though 12.5% of the global population suffers from mental illness, the office estimates that the rate for the African continent may be similar—or it may be as high as 20 to 30%.[53] Regional offices even differ in their definition of “mental health.” The Africa Office includes alcohol and tobacco abuse in its definition of a mental health disorder, but most other offices do not.[54] The main
mental illnesses affecting the African continent include epilepsy, depression, PTSD, schizophrenia, and what the office refers to as “common mental disorder.”[55]

AFRO on the whole has fewer publications addressing health challenges compared to the other regional offices. There are no resolutions or plans dedicated to combating obesity. There may be several reasons for this. Obesity is often misconceived as a “rich man’s problem” that is not a priority for a region that continues to experience high levels of poverty and famine, and stubbornly high rates of infectious disease. However, current research shows that the African continent, particularly in more urbanized countries such as South Africa, is also suffering from a growing obesity crisis.[56] For example, a study published in 2009 estimated that between 20 to 50% of the urban population in Africa was either overweight or obese.[57] Based on surveys taken in seven African countries, the study also found that the percentage of the urban population that was overweight or obese increased by around 35% between 1992 and 2005, and that number is set to continue to rise in the upcoming years.[58] While struggling with high rates of poverty and malnutrition, the region must also now tackle the growing obesity problem, the so-called “dual burden of disease” plaguing many low- and middle-income countries. Moreover, the region is also faced with a series of other urgent health-related issues, such as conflict-related injuries, natural disasters, and growing civil unrest that focuses attention away from chronic diseases.[59]

AFRO has undertaken a number of efforts dedicated to mental health, though the majority of them are focused on mental health in relation to violence, alcohol abuse or substance abuse.[60] It has authored the Report on the Mental Health System in Eritrea and a set of Guidelines on Mental Health and Psychosocial Support in Emergency Settings, demonstrating that the region has reasonably decided to prioritize mental health concerns related to conflict and post-conflict zones.[61] The region’s most comprehensive policy document is the Regional Strategy for Mental Health 2000-2010.[62] While the strategy acknowledges that the African region faces unique challenges that most others do not, a number of the key provisions echo those found in similar plans from other regions, including encouraging the engagement of local communities and relevant partners, promoting public education, and increasing financial contribution to capacity building and research.[63] However, this document also has some distinguishing features, such as its limited emphasis on the empowerment of individual with mental health issues which is given significant weight in WHO’s comparable reports.

B. The Americas

NCDs are the leading cause of death in the Americas[64]—they are responsible for 70% of mortality in Latin America and the Caribbean, and it is expected that the prevalence of NCDs in the region will continue to rise.[65] The rise in NCDs is closely tied to the growing rates of obesity and overweight, especially among the poor. 62% of the population is overweight and 26% is obese. In fact, the prevalence of overweight and obesity is the highest among the regions and doubled between 1980 and 2008.[66] The region also faces high rates of mental illness. Prevalence rates for all mental disorders range from 18.7% to 24.2% in the Americas, and recent studies show that depression is the leading type of mental illness in the region—with women impacted twice as often as men.[67] Given this reality, the Americas stand to benefit from meaningful interventions that would not only address the rise of obesity prevalence, but also ensure sufficient attention is paid to the mental health conditions that are linked to obesity, especially among vulnerable populations.
With recent data revealing that 20 to 25% of children under 19 in Latin America are overweight or obese, the Pan American Health Organization (PAHO)—WHO’s regional office in the Americas—as well as the Organization for American States’ (OAS) public health authority have devoted special attention to this population group. In October 2014, PAHO’s Directing Council[68] approved the Plan of Action for the Prevention of Obesity in Children and Adolescents, which established areas of actions to be taken over following five years: 1) promoting breastfeeding, 2) better food and more physical activity in schools, 3) junk food taxes and restrictions on marketing, and 4) increased access to recreational spaces and nutritious foods.[69] However, the plan does not address mental health.

The fact that PAHO’s plan of action on child obesity fails to explicitly mention mental health as a possible concern does not translate into a lack of potential for fostering greater attention to the issue. On the contrary, since the 1980s, PAHO has made significant advancements in the mental health arena, and this experience can serve to meaningfully influence efforts to comprehensively address obesity and its underlying mental health conditions. PAHO has, for example, been an influential actor in promoting and reforming psychiatric practices in the region. As part of its work in the area, in 1990, PAHO led mental health practitioners, human rights lawyers, and national legislators in developing a set of psychiatric standards based on human rights principles known as the Caracas Declaration.[70] This declaration has been described as a “historical milestone” for its call to reform the psychiatric-hospital care into one that is decentralized and sensitive to the needs of the patient. [71] From it followed similar reports that built on this foundation and that continued to promote mental health in the region, including the Brasilia Principles.[72]

Also in October 2014, the Directing Council approved the Plan of Action on Mental Health.[73] However, in this case, the Council recognizes the need for “a comprehensive approach to health and emphasizes the links between physical and psychosocial aspects of the health-disease process.” It refers to NCDs in general, emphasizing that “disease, whether communicable or noncommunicable, increases risk for mental disorders.”[74] Nevertheless, while depression is highlighted and even referred to as linked to diabetes, a direct connection to obesity is not made. What this indicates is that there is an important gap to be filled.

Considering the lack of attention given to the issue, it is worth pointing out that the Mental Health Project, PAHO’s technical unit on mental health, currently sits within the Department of Noncommunicable Diseases and Mental Health (NMH). Tasked with promoting, coordinating, and implementing “technical cooperation activities directed to strengthen the national capacities to develop policies, plans, programs and services,” it would undoubtedly be a key player in encouraging greater action on the part of governments and PAHO itself to work at this intersection. [75]

C. Eastern Mediterranean

As in the Americas, obesity is a growing problem in the Eastern Mediterranean.[76] Recent studies have shown that in the Eastern Mediterranean, the rate of obesity in adult women is escalating particularly rapidly, although the increase in obesity rates is growing across all age and gender groups.[77] As is happening throughout the world, researchers have cited changes in diet—particularly greater consumption of fast food, sugary beverages, calorie-dense items, and the like—as the predominant reason for the rise in the region’s accelerating rate of obesity.[78] As a result, there has been a surge in the number of legal and policy instruments addressing
obesity in the Eastern Mediterranean.

The Regional Office for the Eastern Mediterranean (EMRO) has adopted several resolutions related to NCDs and nutrition to demonstrate its commitment to overcoming this public health challenge.[79] However, these resolutions are not binding upon states and contain few substantive recommendations. The bulk of the policy recommendations instead come from the action plans and programs published by regional offices.

In addition to these resolutions, EMRO has adopted a general plan for addressing NCDs as well as two that are more targeted toward nutrition and diet. The Plan of Action for the Prevention and Control of Noncommunicable Diseases in the Eastern Mediterranean contains six objectives and lists proposed strategies that governments, WHO, and international partners should take to achieve each of these objectives. These objectives include raising the priority of NCDs in public health, strengthening national legislation directed at combating NCDs, promoting tactics to prevent the main modifiable risk factors, increasing research on prevention and control measures, encouraging partnerships with other stakeholders, and monitoring the development of NCD trends across and within regions.[80]

Additionally, EMRO has developed the Framework for the Implementation of the Global Strategy on Diet, Physical Activity and Mental Health in the Eastern Mediterranean Region, a working document that more specifically addresses the factors that have led to a growing obesity rate.[81] The framework includes guiding principles based on those WHO adopted in its own Global Strategy on Diet, Physical Activity and Mental Health, such as developing a strategy that involves more stakeholders, advocating for policy changes based on scientific evidence, and increasing cultural sensitivity.[82] This framework calls on states to develop national nutrition and physical activity guidelines, enforce national and regional plans in coordination with the strategies of other regions, improve urban planning, mobilize resources for implementation and foster partnerships with other stakeholders, and undertake education and public awareness campaigns.[83] The strategy places special emphasis on engaging other actors, particularly certain key private sectors such as marketing departments and the alcohol industry.[84] Again, the failure to mention of mental health as a relevant factor in both of these documents is a clear deficit.

Compared to the framework, the Regional Strategy on Nutrition 2010-2019 Plan of Action offers a more region-specific set of recommendations.[85] The Eastern Mediterranean region faces a particularly thorny challenge: simultaneous epidemics of obesity and malnutrition.[86] Both obesity and malnutrition can cause lingering health effects, including NCDs. The plan details specific target goals that it hopes to achieve by 2019, and provides several strategies for accomplishing them.[87] Most are similar to those found in the global instruments: calling for strengthening political commitment to combating this issue, increasing stakeholder participation, adopting relevant global instruments, providing a comprehensive public education campaign, promoting relevant research, and ensuring a safe and adequate food supply.[88] However, one feature that is unusual to this action plan is Approach 2, which is specifically dedicated towards protecting the wellbeing of women and children, who are particularly vulnerable groups within a population.[89]

EMRO has placed less emphasis on mental health. Most of the documents authored on this subject are in relation to substance or alcohol abuse. The office has, however, published a resolution to address the growing mental health issues in the region.[90] The resolution urges

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states to implement the policies recommended in the Mental Health Systems in the Eastern Mediterranean Region instrument and formally adopt them in their national legislation. It also calls on states to increase research on mental health, support capacity development, and promote public literacy in this area. The Mental Health Systems in the Eastern Mediterranean instrument takes a more holistic approach to the issue, emphasizing connections between mental health and related sectors such as criminal justice, education, employment, and human rights. It also places a stronger emphasis on equal accessibility to support social justice. The instrument lists seven key building blocks: having a more cost-effective method for delivery of service, improving the workforce, ensuring a more equal distribution of resources, adopting more effective legislation, increasing financing for mental health-based programs, and promoting better leadership and governance.

Though the region does not suffer from rates of obesity and overweight as high as, for example, Europe or the Americas, it must take necessary steps to develop programs to stem its growing obesity problem while simultaneously tackling issues related to malnutrition. It would also significantly benefit from adopting instruments that acknowledge the connection between mental health and obesity in order to effectively combat both issues.

D. Europe

The Office for Europe (Europe Office) was one of the first to recognize that obesity was a significant problem. Data from the European Union shows that the percentage of the population that is overweight or obese has been growing steadily since at least the 1990s. It is estimated that between 30 to 70% of the adult population is overweight while 10 to 30% of the adult population is obese. In response to this escalating problem, the Europe Office has produced a litany of evidence-based reports and policy recommendations. It has placed considerable emphasis on combating both mental health issues and obesity. Its policy goals for obesity are to monitor medical and social factors that cause obesity, develop programs that address them, and reduce the prevalence of these factors.

The office has authored a variety of plans, charters, and resolutions related to obesity. The Action Plan for the Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012-2016 is refreshingly progressive, explicitly acknowledging the connection between NCDs and mental health. However, the strategy only addresses the four main NCDs, which are cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases. The central legal instrument addressing obesity in the region is the European Charter on Counteracting Obesity. Thus far, the Europe Office is the only office to have drafted a document specifically targeting obesity, as opposed to instruments that address NCDs in general or nutrition more broadly. The charter recommends engaging all relevant stakeholders including each level of government, the private sector, civil society, and even the media. It states that intersectoral collaboration is necessary for an effective response to growing obesity rates. The report also details six priority actions to prevent obesity: supporting a healthy start for infants and young children, ensuring a sustainable supply of healthy food, providing comprehensive information to consumers, developing programs to promote physical activity and decrease alcohol consumption, strengthening nutrition guidelines, and developing monitoring and enforcement mechanisms. In addition, the charter calls for states to review the WHO European Charter on Counteracting Obesity, the WHO European Action Plan for Food and Nutrition Policy, and the EU White Paper: Strategy for Europe on Nutrition, Overweight, and Obesity Related Health Issues for guidance on effective policies.
The Europe Office’s goals for mental health are to decrease the stigma associated with mental illness, address the problem of deinstitutionalization, emphasize individual choice and recovery, increase understanding of mental health as a cause as well as an effect of other illnesses, develop legislation with a human rights focus, and ensure that the measures taken are cost-effective.[105] It estimated that roughly 27% of the adult population experienced one mental disorder this past year; this equates to over 83 million people affected on the European continent alone.[106] According to the office, “[m]ental disorders are by far the largest contributor to chronic conditions afflicting the population of Europe.”[107]

The regional office issued a fact-based document entitled the Policies and Practices for Mental Health in Europe, which is comprised of a series of charts and tables that list which programs and policies exist in each member state.[108] All but four member states have implemented at least a minimal mental health plan and 29 countries have adopted mental health-related legislation.[109] The main guiding instrument is the European Mental Health Action Plan, which was established by Resolution EUR/RC63/R10.[110] The action plan outlines the suggested policies for member states to incorporate into their national legislation, and provides greater specificity on the programs and strategies that could lead to their achievement. These policies include developing a suicide prevention and support program, promoting individual dignity and positive self-image, making mental health programs more prevalent and accessible to all populations, ensuring that staff in the mental health field are appropriately trained, augmenting the quality of medical care provided, increasing coordination with related organizations advocating for the same issues, and sponsoring research and dissemination of information efforts.[111]

**E. Southeast Asia**

Southeast Asia is characterized by its low rates of obesity and is the WHO region with the lowest percentage of people who are overweight and obese in the world.[112] By way of comparison, the percentage of the population that is overweight is four times higher in the Pan-American region than the Southeast Asian region.[113] Therefore, it is perhaps unsurprising that the Office for Southeast Asia has not authored a single document that addresses obesity directly. However, the office has published a legal framework addressing NCDs generally, which offers generic recommendations for states including increasing institutional capacity and financial contributions, developing monitoring mechanisms, and promoting healthcare systems to have a greater capacity for early detection and quality treatment.[114]

Mental health has also traditionally been a low-priority issue in Southeast Asia.[115] There is little national legislation in place addressing these issues in many states and total spending on mental health is around 2% in most countries in the area.[116] The Office for Southeast Asia has only authored one publication on mental health, and that report is targeted towards dealing with the aftermath of the 2004 tsunami that devastated the region.[117] The policies are targeted towards dealing with mental health issues that arise in response to tsunamis, earthquakes, and other natural disasters.[118]

In general, the Southeast Asia region needs to place a stronger emphasis on addressing issues related to obesity and mental health illnesses. Compared to other regional offices, it has allocated the least resources and focus on either of these problems. It would benefit from a close analysis of the recommendations found in global instruments and the application of all relevant policies.
F. Western Pacific

Similar to other regions composed predominantly of developing states, the Western Pacific region has recently faced growing levels of obesity. This is in part due to a shift away from traditional diets towards processed foods. At least ten Western Pacific Island countries have an obesity rate of 50% or above.[119] At the same time, the region also suffers from high rates of malnutrition and micronutrient deficiencies.[120] Unlike some of the other regional offices that have listed the issue of obesity under the NCD heading, the Office of the Western Pacific Region (Western Pacific Office) has categorized obesity under nutrition.[121] The strategy most popular in this region to combat obesity is a market-based approach that attempts to encourage the consumption or rejection of certain foods or beverages through trade and financial regulation laws. For example, several states have introduced so-called “sin taxes,” which are taxes on unhealthy foods that are used to fund programs that promote healthy diet and exercise.[122]

The regional office has taken a more legal approach to combating obesity compared to the other offices. Its two main documents on this issue are both directly geared towards using legislation as the main strategy for overcoming obesity. The first, Using Domestic Law in the Fight Against Obesity, suggests three regulatory approaches: the use of pricing controls on the food industry such as tariffs, domestic subsidies, and domestic taxes; the restriction on the supply of certain types of foods from entering the market; and the enforcement of certain labeling and warning requirements on food packaging.[123] The guideline focuses on the use of trade-based mechanisms to control the entry and consumption of certain food items, and has a section dedicated to compliance with the WTO Agreements.

The second document developed by the regional office is the Legislative Interventions to Prevent and Decrease Obesity in Pacific Island Countries, which recommends policies for member states to adopt and provide evaluations on the effectiveness and feasibility of the policies.[124] Many of these policies are also trade- and market-based, including the taxation or banning of unhealthy foods, subsidizing healthy alternatives, regulating practices on labeling and advertising, and restricting the food options available to children.[125] Compared to Using Domestic Law in the Fight Against Obesity, this publication also offers more social and developmental practices such as promoting healthier eating and physical activity campaigns to schools and the public, and increasing cooperation with regional and international advocacy groups.[126]

The mental health publications from the Western Pacific Office are largely related to rehabilitation efforts, suicide prevention, and alcohol and substance abuse.[127] Few of the documents address mental health as an issue in and of itself. The central report dedicated to mental health was published in 2002 and is therefore not as current as the flagship pieces of other regions. The Regional Strategy for Mental Health suggests two approaches.[128] First, the intersectoral approach promotes bringing different agencies together to collaborate on illness prevention and treatment.[129] Second, the integrative approach seeks to bring together families, communities, and advocacy groups to tackle the problem collectively.[130] The document urges member states to increase advocacy on the issue, improve delivery of services at a national and local level, increase awareness around the situation by providing supplemental support to vulnerable populations, introduce new legislation to combat factors leading to increased mental illness, encourage a culture of research and information sharing, and implement a program specifically to prevent suicide.[131]

In addition, a number of Ministers of Health from the region gathered to create the WHO Pacific...
Islands Mental Health Network in 2007 in response to this emerging problem. While not all states joined the network, it has achieved some progress. The network has established an operational and decision-making structure, and has published several plans and frameworks directly addressing regional factors since its formation.

G. A varied landscape

This survey of existing initiatives reveals an overall lack of awareness about the relationship between obesity and mental health that leads even many health authorities to overlook the need to design policies that integrate the two issues. There are many varied opportunities available to policymakers that could encourage greater efforts to undo the so-far-segregated approach to obesity and mental health.

Having made greater progress than most of its regional office in this area with respect to developing action plans, programs, instruments, and other materials to guide this re-conceptualization of obesity and mental health, WHO is well positioned to take the lead. Not should WHO formulate its own policies and guidance, it can also create opportunities for regional offices, particularly those in regions facing the greatest rates of obesity, to also develop and strengthen their efforts to have a meaningful impact on the ground. In the same vein, those regional offices that have been able to better advance in this area or are at least farther along in either the obesity or mental health arenas to help guide other regional offices in their efforts. For example, EMRO has made significant progress in developing initiatives that directly address obesity and PAHO has made substantial achievements in the area of mental health. With WHO already recognizing the link between the two issues, there is ample room for creating opportunities where regional offices could identify best practices and build new initiatives to address the problem.

Building on the gaps highlighted, the following section discusses recommendations for how the mental health can be integrated into existing or future efforts at the international, regional, and national levels relevant to obesity.

V. RECOMMENDATIONS

Currently, the international community is in the midst of several large-scale shifts in the development of health policy, at least notionally shifting the system towards one founded on the principle of equity and human rights with the emerging movement towards Universal Health Coverage (UHC) and the creation of post2015 Sustainable Development Goals (SDGs). These movements have created a window of opportunity for health advocates to take action and push for significant changes. The following sections offers two sets of recommendations. First, it outlines recommendations for WHO and its regional offices that are necessary for WHO to reassert its role as the international leader on these health topics. Second, it lists recommendations for domestic governments to implement at the local level.

A. Capitalizing on the global movement towards health access and justice

Universal Health Coverage (UHC)

UHC aims to achieve better health outcomes by promoting health systems that ensure every
individual quality and affordable health care services.[134] It is understood as being built on “universal, timely, and effective access to services” and requiring “determining and implementing policies and actions with a multisectoral approach to address the social determinants of health and promote a society-wide commitment to fostering health and well-being.”[135] Founded on equity and the right to health, as understood under WHO’s Constitution, this initiative draws special attention to the needs of the poor and other vulnerable populations, including children and women.

Current global efforts to promote UHC reflect a serious concern over widespread health inequity across the world. Considering the heavy financial burden that health services impose on individuals across the world and the need to reform health-financing systems, WHA issued a resolution in 2005 that called on governments to transition to UHC.[136] It was followed by WHO’s 2010 report Health Systems Financing: the Path to Universal Coverage, which provides guidance on how countries “can modify their financing systems to move more quickly towards universal coverage and to sustain those achievements.”[137] This publication set in motion what has become a global movement to provide quality and affordable health services.

Importantly, this call to ensure equitable access to health care received the meaningful support from the U.N. General Assembly. In December 2012, it adopted a resolution that linked health and development, and declared UHC a priority for sustainable development.[138] Other major players have also joined the global effort to bring UHC, including the World Bank, United Nations Children’s Fund (UNICEF), the United States Agency for International Development (USAID), the Inter-American Development Bank, the Rockefeller Foundation, and the Bill and Melinda Gates Foundation.

UHC stands as a natural avenue for addressing the financial burden that obesity and related mental health conditions can impose on affected individuals and their country’s health system. Recognizing that vulnerable populations and the poor are the most at risk of suffering from obesity, greater advocacy would be needed to ensure that the UHC agenda globally, regional, and domestically recognizes the mental health implications of obesity and adequately addresses the needs of affected populations. If the issue is not integrated into the agenda, we would be overlooking a significant contributing factor to a country’s rising health care costs, especially in regions experiencing a concerning rise in obesity rates, such as the Americas and the Eastern Mediterranean.

**Sustainable Development Goals (SDGs)**

Recognizing that major actors need to play a leading role in setting the agenda for formulating and achieving international developmental goals, the U.N. spearheaded the MDG project, which sought to tackle the eight most significant development issues the international community was facing at the time.[139] As the MDGs are set to expire at the end of 2015, the U.N. has formed a working group that is currently soliciting proposals for plans from relevant stakeholders for SDGs, a comprehensive set of global targets that are designed to replace the MDGs.[140] The SDGs will combine existing MDGs with post-MDG goals, and expand upon the issues that need to be prioritized in the coming years. Many targets have been proposed by different actors including inter-governmental organizations, public policy and research institutions, NGOs, and state governments. These goals span a variety of topics including the promotion of human rights, reduction of poverty, protection of the environment and biodiversity, adoption of more public-private partnerships, and improvement of healthcare systems and urban planning.[141]
The international community is in the midst of negotiating its next set of high-profile goals that states around the world will pledge to achieve. It is expected that one goal will be focused on promoting health, and will contain at least one sub-target dedicated to NCDs, under which both mental health and obesity are likely to be subsumed.

SDGs are significant because they set the global agenda for global development. Advocates can take advantage of these negotiations by pushing for the acceptance of certain sub-targets within the NCD heading which are applicable to both mental health and obesity. These conversations will invariably develop methods for establishing standards, creating measuring sticks, and implementing guidelines in order to increase state accountability in meeting the targets—all useful tools that advocates can use to combat obesity and mental health illnesses. It is crucial that the international community confront the escalating issue of NCDs seriously as countries cannot develop and prosper without healthy populations.

B. Recommendations for WHO and its regional offices

There are several affirmative steps different actors within the international community can take to advance the fight against mental health problems and obesity. In order to produce effective results, action must be taken at all levels of governance and by all actors. This section offers recommendations for WHO at the global and regional level.

Recommendation One: Further Develop Flagship Documents on Mental Health and Obesity. WHO should develop its existing flagship documents on mental health and obesity in two ways. First, policies addressing the connection between mental health and obesity should be added to both action plans to allow the documents to work in conjunction. Second, WHO should expand upon the generic policy recommendations found in its existing documents by looking at practical research. Specifically, it should compile a comprehensive list of the best practices of states worldwide and also consider the recommendations found in the Advocacy Toolkit on NCDs in Post-2015 developed by the NCD Alliance. Though aimed at advocacy groups and civil society, the toolkit provides significant insight into national and regional policies to further the prevention and control of NCDs.[142]

WHO has already compiled a list of best practices for addressing mental health in the 2008 Mental Health Gap Action Programme, but it has yet to produce a comparable report for obesity or NCDs in general. While crafting such a guideline for NCDs, WHO should look both to the prototype established by the 2008 Mental Health Gap Action Programme and the Policies and Practice for Mental Health in Europe document published by the Office for Europe. The latter contains overall statistics on the proportion of states that have adopted certain policies and programs in the region, and details about which states have implemented these policies.[143] The tables encompass a wide variety of rules and policies related to mental health such as access to assertive outreach programs, ratio of beds available for inpatients in community residential health facilities, availability of specialized youth services, and training requirements for psychiatrists under national standards.[144] In order to gather all the relevant information, the Office for Europe created a survey of the resources and personnel allocated, programs available, and legislation targeted towards addressing mental health problems.[145] Each country in the region was given the option of completing the survey online or on paper.[146] The regional office also assigned representatives to provide additional support and clarify instructions for all states participating in the survey.[147] Though the regional office did not verify each survey answer, it did crosscheck the data from past surveys conducted by WHO and ask states to
support questionable assertions.[148]

Though the guideline proffered by WHO should be based on this model used by the Office of Europe, it should also take the initiative a step further. For each policy recommendation, it should include foundational scientific evidence and any evaluative notes from states that have implemented a comparable policy as is found in the 2008 Mental Health Gap Action Programme. This is to allow states to learn from others’ experiences and to ensure the most efficacious regulations are put in place. The document should be disseminated to the regional offices and individual states. As the regional offices are in the best position to understand the needs and circumstances of the countries in their geographic block, they have the obligation to then parse the data to identify the recommendations that are most applicable to their region. They should take affirmative action to encourage states to adopt and implement the policies that most directly address their specific situations by providing financial and technical support.

In addition, WHO should encourage states through the guidelines to conduct regular evaluations of the efficacy of the policies to ensure that redundant regulations are dropped, allowing governments to refocus their resources and energy towards the most effective and beneficial programs. A feedback mechanism should also be developed to allow states to share their successes and shortcomings implementing different policies with the rest of the international community. While WHO’s guidelines will be written, the field must remain a dynamic one surrounded by continual dialogue as governments and experts persist in creating and adopting regulations to improve public health.

**Recommendation Two: Develop an Information-Sharing Network.** WHO should develop an information-sharing network that connects regional offices and individual states. This network would allow governments, healthcare providers, and research institutions to share relevant information such as current research, existing and pending legislation, and evaluations of the efficacy of existing policies, where possible. It can build upon existing networks as there are several non-legal, scientific-based networks already functioning. For example, the US National Heart, Lung, and Blood Institute and the UnitedHealth Group have collaborated to form a network of 11 centers in over 30 countries that aims to share information about battling NCDs in low- and middle-income countries.[149] This network focuses more on sharing surveillance data and medical information, while a network that includes sharing legal- and policy-based analysis is also necessary.

The most prevalent information-sharing network for the control and prevention of obesity is PreventObesity.net.[150] However, this organization is focused predominantly on obesity within the domestic context of the United States. As such, most of its contributors are U.S. institutions and organizations, and its work is targeted towards supporting the U.S. population.

By providing a platform that facilitates the free exchange of ideas and information between stakeholders, experts around the world would be able to pool their knowledge on combating mental health issues and obesity. This strategy has two benefits. First, it increases the efficiency of medical experimentation in this field because it decreases the repetition of research. Second, it allows states to learn from each other’s successes and mistakes, as it would give them access to the policies that allowed similarly situated states to effectively overcome obstacles.

Versions of this information-sharing network already exist in other areas of global health law. A prime example is the infectious disease sector, which is the home to a host of surveillance
networks that share data about the geographical spread, incident number, and death count of emerging infectious diseases.[151] These networks help healthcare experts track the progress of a disease as it makes its way through a population or across borders, and allow policymakers to develop a targeted strategy to combat the outbreak. Many of these networks are organized and run by nongovernmental organizations (NGOs) or research institutions, such as ProMED-mail, the Global Influenza Surveillance Network, and the Global Polio Eradication Initiative. Others are run by specific countries such as the Biological Threat Reduction Program which was established by the US Department of Defense, and the Global Disease Detection Program which was established by the Center for Disease Control. Still others are considered part of WHO, including the Global Influenza Surveillance Network and the Global Outbreak Alert and Response Network.

One of the key beneficial features of the networks for infectious diseases is that it allows real-time transmission of information that is crucial for the containment of a bacteria and virus that spread rapidly. While such instantaneous communication of information is not as necessary for either mental health or obesity, which are both longer-term illnesses, the timely sharing of new data is nevertheless significant. WHO should develop a model for an information-sharing network to promote the fight against mental health problems and obesity. Though WHO currently does have an infrastructure called NCDnet, its aim is limited towards implementing the Noncommunicable Diseases Action Plan and does not address other problems that are related to NCDs more broadly.[152] Moreover, the main actors in the network are WHO, its regional offices, and NGOs. Our proposal calls for a wider network that involves all relevant stakeholders including research facilities, national governments, and civil society.

**Recommendation Three: Increase Initiatives that Directly Address the Connection Between Obesity and Mental Health.** While progress has been made in understanding obesity and mental health problems separately, a great deal of work remains to address the interaction between them. In order to rectify this, WHO should commission a study specifically on the connection between obesity and mental health. A deeper understanding of the science underlying these phenomena needs to be acquired in order to develop an effective set of policies to combat them. In addition, regional offices should conduct studies to gather more targeted information regarding the specific needs of their region. For example, the Office for Southeast Asia and PAHO would likely want to dedicate a greater share of resources towards understanding how the soaring popularity of fast food and the shift away from traditional diets have impacted obesity rates, and the impact that has had on mental health.

Furthermore, WHO and its regional offices should pioneer more initiatives that target the relationship between obesity and mental health illnesses, regardless of the direction of causation. Thus far, all instruments and policy guidelines at both the global and regional level are directed towards tackling each issue separately. However, as there is clearly a connection between them, it is necessary to have a strategy that addresses them together. For example, WHO should take steps either through the guideline outlined in Recommendation One or in a separate program to encourage states to introduce legislation that ensures medical care professionals are adequately cross-trained in relevant fields. That is, psychiatrists and mental health counselors should also receive mandatory training in topics such as recognizing and understanding nutritional problems that could lead to obesity or other unhealthy lifestyles. While the world has trended towards increased specialization, areas of public health are so interrelated that in order to adequately combat them, all factors must be addressed.

**Recommendation Four: Introduce Policies that Seek to Protect Vulnerable**
Populations. Finally, regional offices should ensure that all instruments addressing mental health or obesity include provisions that offer greater protection for vulnerable and high-risk populations. Many of the existing regional instruments, action plans, and programs addressing these issues already contain policies that encourage states to introduce regulations that target particularly at-risk populations such as youths, women, and minorities. For example, the WHO Global Noncommunicable Diseases Action Plan urges states to empower communities, and places a special emphasis on vulnerable populations such as access among the young and elderly to NCD prevention and treatment services.\[153\] Often, these are the populations that are more likely to be marginalized and less able to access adequate healthcare, and it is the duty of national and regional bodies to ensure that their needs are met.

C. Recommendations for National Governments

States play the most important role in decreasing incidence of obesity and mental illness, and for severing the link between the two. By strengthening laws and policies, better equipping health systems, and implementing strong public health campaigns, states can tackle obesity and associated mental health disorders, and help to break the association between the two. States must take action for global and regional recommendations to make a difference, and the negotiation of the SDGs and the movement towards UHC are creating a particularly opportune moment for states to reevaluate their legal and policy frameworks.

Recommendation One: Strengthen Laws and Policies to Better Control Obesity and Mental Health. States should pass laws and create policies that help to prevent both conditions independently. As discussed above, WHO and its regional bodies have developed a wide array of guidelines and tools states may use in crafting appropriate legislation and other rules and guidelines. States also have a vital role in addressing the link between obesity and mental illness, and help to break the association between the two. The WHO best practices document, suggested above, will prove an important guide to states to help them to better identify gaps and more effectively shape their laws and policies.

Recommendation Two: Equip Health Systems to Better Address the Link Between Obesity and Mental Illness. States should better equip their health systems to address the link between obesity and mental illness. The first step should be to fund research dedicated towards a more complete understanding of the link between obesity and mental health at the national level. States may wish to conduct research directly, or fund universities, NGOs or private companies to conduct the research. Special attention should be paid to studies that measure the impact on subpopulations, such as women, youth, those of different socioeconomic status or level of education, racial or ethnic minorities, etc.

Based on the results of these studies, and on the recommendations developed by WHO and its regional bodies, countries should develop or update national medical protocols and guidelines to aid practitioners and medical facilities to better serve those who are at risk of co-morbidities. These protocols and guidelines should take into account any unique risks that subpopulations may encounter. States should incorporate these protocols and guidelines into medical education to equip the next generation of doctors and other medical professionals to better serve their patients.

Recommendation Three: Implement Public Health Campaigns to Raise Awareness. Finally, states and local governments should undertake public health campaigns to raise awareness of the link between mental illness and obesity. One such campaign could be public-
facing for instance de-stigmatizing mental health and obesity and helping patients afflicted with one to be on the lookout for symptoms of the other. Another could be focused on health providers at all levels, which in conjunction with updated medical protocols and guidelines, could help them to better recognize and respond to co-morbidities.

VI. CONCLUSION

The world has begun to appreciate the immense global health burden of obesity and mental health independently, yet insufficient attention has been paid to researching—and still less to developing legal and policy interventions—addressing the link between the two. Effectively confronting this link will not be simple. It will require action at the global, regional, national and local levels, as well as the integration of two areas of medicine and health policy that do not often overlap.

However, the gains of a collaborative approach could be considerable. On an individual level, breaking the link could alleviate a great deal of suffering of people who are currently suffering both physically and mentally. On a population level, an effective response could lower incidence of both mental health and obesity, resulting in societies that are healthier, happier, and more productive.

[1] J.D. candidate 2015, Georgetown University Law Center, Washington, D.C. USA. The authors would also like to express their gratitude to research assistants Emily Wong and Diya Uberoi for their invaluable contributions to the research and editing of this article.


[12] Id.


[19] Id.

[20] Id.

[21] Id.
[22] Markowitz, supra note 18.

[23] Id.

[24] Id.


[29] Id. at 58.

[30] Id. at 23.

[31] Id. at 39-43, 58.


[35] WHO, Mental Health Policy, supra note 34.

[36] WHO, Mental Health Context, supra note 35 at 6-8, 22-23, 30-34.


These eight priority conditions included depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to illicit drug use, and mental disorders in children.

Id. at 11-12.

Id.

Id. at 21.

Id. at 13.

WHO, supra note 27.

Id. at 15-26.

Id. at 10.

Id. at 23.


Id. at art. 17, 25.


Id. at art. 12.

[53] Id. at 5

[54] Id. at 16.

[55] Id. at 4-6.


[58] Id.


[61] Id.


[63] Id.


[67] PAHO, supra note 65, at paras. 8-9.

[68] The body in charge of setting policies and priorities for PAHO.


[71] PAHO, supra note 68.


[73] PAHO, supra note 68

[74] Id.

[75] Id.


[78] Id.


[82] Id. at 8-9.

[83] Id. at 10-18.

[84] Id. at 13-14.


[86] Id. at 5, 7-8.

[87] Id. at 11-14.

[88] Id. at 12-14, 15.

[89] Id. at 12.


[91] Id.

[92] Id.


[94] Id.

[95] Id. at 41-43.

[98] Id.


[104] Id.


[109] Id. at 14.


[113] Id.


[116] Id.


[118] Id.


[120] Id.

[121] See Programs and Special Initiatives, World Health Org.: Western Pacific Region (March 9, 2015), http://www.wpro.who.int/entity/en/.


[124] Clarke, supra note 123.

[125] These types of taxes are colloquially known as “sin taxes” because they are imposed on food, beverages or goods that are considered harmful.

[126] Clarke, supra note 123, at 12-17.


[129] Id.

[130] Id.

[131] Id. at 15.


[133] Id.


[135] Id. at para. 6.


[144] *Id.* at 66, 72, 78, 105.

[145] *Id.* at 6.

[146] *Id.*

[147] *Id.*

[148] *Id.*


[151] Penny Hitchcock et al., *Challenges to Global Surveillance and Response to Infectious Disease Outbreaks of International Importance*, 5 Biosecurity and Bioterrorism 206 (2007).
